ICF/IID Comprehensive Nursing Assessment

To be performed by a Registered Nurse
(Example Form)

Individual	Date of Birth	Today's Date

I. Review

Review of Health Care Team	Health Care Practitioners	Date Last Seen	Comments
Primary Care			
Psychiatrist			
Neurologist			
Dentist			
Optometrist			

Natural Supports	Relationship	Area Code and Telephone No.
Guardian/Legally Authorized Representative (LAR)		

Health History

Axis I:

Axis II:

Axis III:

Axis IV:

History of Major Medical/Surgical Occurrences:

RN _____

Individual _____ Date _____

Review of Current Medications **Include OTCs, vitamins and herbs**					
Allergies:					
Medication	**Dose**	**Freq.**	**Route**	**Purpose/Rationale**	**Side Effects/Labs**

RN _____

Individual _____ Date _____

II. Current Status

Current medical and psychiatric history
Briefly describe recent changes in health or behavioral status, hospitalizations, falls, seizure activity, restraints, etc., within the past year.

What is of primary concern/greatest expressed needs of the individual, guardian/LAR and Interdisciplinary Team (IDT) from their own perspective?

Vital Signs

Blood pressure	Pulse		Respirations	
	Rate	Rhythm	Rate	Rhythm

Temperature	Pain level	Blood sugar	Weight	Height

Labs

Briefly review ordered labs, dates and abnormal values within the past year.

RN _____

Individual _____ Date _____

III. Review of Systems

Neurological

AIMS Assessment: ☐ Attached ☐ Deferred **Fall Risk Assessment:** ☐ Attached ☐ Deferred

	Y	N		Y	N		Y	N
Headaches……	☐	☐	PERLA……...	☐	☐	Tremors…….	☐	☐
Dizziness……..	☐	☐	Tremors…….....	☐	☐	Heat/Cold Reflex…….	☐	☐
Impaired Balance/ Coordination…….	☐	☐	Numbness/Tingling/ Paresthisia……	☐	☐	EPS……	☐	☐
Med side effects affecting...	☐	☐	Paralysis……	☐	☐			

	Y	N		Y	N		Y	N
Seizures……	☐	☐	Petit Mal…….	☐	☐	Clonic (repetitive jerking)……	☐	☐
Frequency _____			Absence…….	☐	☐	Tonic (muscle rigidity)…….	☐	☐
Duration _____			Myoclonic (sporadic jerking)..	☐	☐	Atonic (loss of muscle tone)..	☐	☐

Comments

EENT

Eyes/Vision
☐ Clear ☐ Red ☐ Right impaired ☐ Left impaired ☐ Adaptive aid

Ears/Hearing
☐ Normal ☐ Ringing ☐ Right impaired ☐ Left impaired ☐ Adaptive aid

Nose/Smell
☐ WNL Smell: ☐ intact ☐ not intact ☐ Nose bleeds ☐ Frequent sinus congestion ☐ Frequent sinus infection

Oral
☐ WNL ☐ Difficulty chewing ☐ Mouth pain ☐ Halitosis ☐ Dentures ☐ Edentulous ☐ Involuntary tongue movement
☐ Dry mouth from meds

Throat
☐ WNL ☐ Sore throats ☐ Difficulty speaking ☐ Difficulty swallowing ☐ Tonsil ☐ History of choking enlargement
☐ Thyroid enlargement
Swallow Study: ☐ Yes ☐ No Date: Results:

Comments

RN _____

Individual _____ Date _____

Cardiovascular

	Y	N		Y	N		Y	N
Edema……	☐	☐	Cool/Numb Extremities……	☐	☐	Capillary refill brisk…….	☐	☐
Chest pain……..	☐	☐	Activities of daily living (ADL) limitations……..	☐	☐	Ted hose…….	☐	☐
High/Low Blood Pressure...	☐	☐						

Normal Range _____

Comments

Gastrointestinal

☐ Gastrostomy ☐ Jejunostomy ☐ No tube

Bowel Sounds Last BM Bowel Habits (frequency and description)

	Y	N		Y	N		Y	N
Continent……	☐	☐	Reflux…….	☐	☐	History of Risk Constipation	☐	☐
Frequent nausea……..	☐	☐	Straining pain……	☐	☐	History of Risk Impaction…..	☐	☐
Frequent vomiting…….	☐	☐	Diarrhea…….	☐	☐	Bowel Program……...	☐	☐
Indigestion…….	☐	☐	Odd stools…….	☐	☐	Meds influencing bowels (laxatives, anti-diarrheals, Iron, Ca, Anticholinergics,		
Heartburn……...	☐	☐	Hemorrhoids…….	☐	☐			
Appetite loss……..	☐	☐	Independent toileting……..	☐	☐	etc.)……..	☐	☐

Comments

Respiratory

Breathing: ☐ Slow ☐ Normal ☐ Rapid ☐ Shallow ☐ Painful

	Y	N		Y	N		Y	N
SOB……	☐	☐	Feeding tube…….	☐	☐	Trach……	☐	☐
Wheezing……...	☐	☐	Positioning orders……	☐	☐	CPAP……...	☐	☐
Fatigue……...	☐	☐	Aspiration history…….	☐	☐	Inhalation agent…….	☐	☐
Cough…….	☐	☐	Pneumonia history……..	☐	☐	Oxygen @	☐	☐
Productive…….	☐	☐						

Comments

RN _____

Individual _____ Date _____

Musculoskeletal

Fall Risk Assessment: ☐ Attached ☐ Deferred

	Y	N		Y	N		Y	N
Pain……	☐	☐	Prosthesis……	☐	☐	Impaired ROM……	☐	☐
Weakness……	☐	☐	Deformity……	☐	☐	Impaired gait…….……	☐	☐
Stiffness……	☐	☐	Contractures……..	☐	☐	Adaptive equipment…...	☐	☐

Comments

Genitourinary

	Y	N		Y	N		Y	N
Continent……...	☐	☐	Flank pain……..	☐	☐	Sexually active……	☐	☐
Stress……	☐	☐	History of UTIs……..	☐	☐	Prostate issues……...	☐	☐
Urge……	☐	☐	Noctouria……	☐	☐	Cycle regular……..	☐	☐
Bladder program……..	☐	☐	Discharge……..	☐	☐	Date LMP: _____		
Frequent urination……	☐	☐	Itching…….	☐	☐			
Cloudy/dark urine……..…	☐	☐	Hemodialysis…….	☐	☐			
Bloody urine……..	☐	☐	Peritoneal dialysis……	☐	☐			

Comments

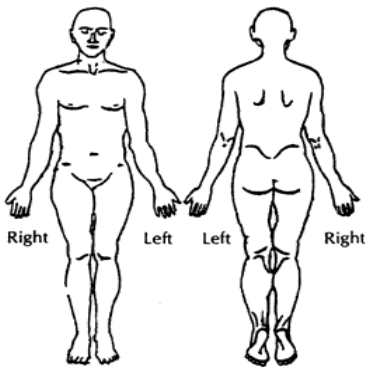
Integumentary

Braden Skin Assessment: ☐ Attached ☐ Deferred

Skin: ☐ Normal ☐ Moist ☐ Dry ☐ Cyanotic ☐ Warm ☐ Pale ☐ Jaundice ☐ Cold ☐ Dusky ☐ Flushed

	Y	N		Y	N		Y	N
Open wound…….	☐	☐	Rash……...	☐	☐	Blemished……	☐	☐
Bruising……..	☐	☐	Diaphoretic……	☐	☐	Poor skin turgor…….	☐	☐
Breakdown related to adaptive aids/prosthesis….	☐	☐	Risk for breakdown……..	☐	☐	History of breakdown….	☐	☐
Risk of breakdown……...	☐	☐						

Comments



RN _____

Individual _____ Date _____

Endocrine

	Y	N		Y	N	
Thyroid dysfunction…….	☐	☐	**Diabetes……**	☐	☐	Type _____
Atypicals or other meds affecting blood sugar……..	☐	☐	Management: ☐ Diet ☐ Oral meds ☐ Insulin			
Pre-Diabetic Hypoglycemic/ Hyperglycemic episodes….	☐	☐	Typical Ranges:			

Comments

IV. Additional Health Status Information

Immunizations: Date last received

DPT	TOPV	HIB	MMR	TD	TDS	Flu Shot

Nutritional Assessment

How Receive Nutrition: ☐ Orally ☐ Via gastronomy tube if residual < _____ ☐ Via jejunostomy tube

Therapeutic Diet _____ Liquid consistency _____

Food Texture _____ Reason/Date/Ordered by: _____

	Y	N	
Recent weight change…….	☐	☐	_____ lbs. ☐ gain ☐ loss over _____
Recent changes in appetite/medication…….	☐	☐	
Satisfied with current weight……...	☐	☐	Desired weight range _____
Food use as a coping mechanism…….	☐	☐	
Assistive devices with eating……...	☐	☐	
Use of meds that can cause difficulty swallowing (e.g., Abilify, other psychoactives)	☐	☐	
Knowledge of 4 basic food groups……..	☐	☐	
Access to healthy/appropriate diet…….	☐	☐	
Dietary deficiencies…….	☐	☐	
Adequate fluid intake…….	☐	☐	
Nutritional supplements…….	☐	☐	
Interactions with meds and food……..	☐	☐	

RN _____

Individual _____ Date _____

Sleep Patterns

Average no. of hours per night; difficulty falling asleep; no. of times awake at night; no. of naps during a day

Activity Level/Exercise

Substance Use/Abuse

Caffeine, tobacco, alcohol, recreational drugs, history of non-compliance with prescribed meds

Home Life

Satisfaction/Desires

Work/School/Day Activity

Satisfaction/Desires

Social Life

Satisfaction/Desires

Spiritual Life

Satisfaction/Desires

Coping Skills

RN _____

Individual _____ Date _____

Mental Status

Appearance

Posture: ☐ Normal ☐ Rigid ☐ Slouched ☐ Other:

Grooming and Dress: ☐ Appropriate ☐ Inappropriate ☐ Disheveled ☐ Neat

Facial Expression: ☐ Calm ☐ Alert ☐ Stressed ☐ Perplexed ☐ Tense ☐ Dazed ☐ Other:

Eye contact: ☐ Eyes not open ☐ Good contact ☐ Avoids contact ☐ Stares

Speech Quality: ☐ Clear ☐ Slow ☐ Slurred ☐ Loud ☐ Rapid ☐ Incoherent ☐ Mute

Mood

☐ Cooperative	☐ Uncooperative	☐ Depressed	☐ Euphoric
☐ Excited	☐ Agitated	☐ Anxious	☐ Suspicious
☐ Irritable	☐ Scared	☐ Hostile	☐ Angry
☐ Other/Describe			

Cognition

	Y	N		Y	N		Y	N
Cognitive impairment			**Oriented**			**Attention span**		
Mild……	☐	☐	Person……	☐	☐	Easily distracted……	☐	☐
Moderate……	☐	☐	Place……..	☐	☐	Impaired judgment……	☐	☐
Severe……	☐	☐	Time……	☐	☐			
Profound……	☐	☐						

Memory

Remote……..	☐	☐
Recent……	☐	☐
Immediate Recall…….	☐	☐

Emotions

	Y	N		Y	N		Y	N
Euphoric……	☐	☐	Depressed…….	☐	☐	Hostile feelings…….	☐	☐
Happy……	☐	☐	Anxious……..	☐	☐	Labiality of emotions……	☐	☐
Apathetic……	☐	☐	Irritable……...	☐	☐	Inappropriate affect……..	☐	☐
Sadness…….	☐	☐						

Thoughts

	Y	Denies		Y	Denies		Y	Denies		Y	Denies
Delusions……	☐	☐	Hallucinations…..	☐	☐	Process…….	☐	☐	Content……...	☐	☐
Grandeur……..	☐	☐	Visual…….	☐	☐	Coherent organized…….	☐	☐	Phobias……..	☐	☐
Persecutory…….	☐	☐	Auditory…….	☐	☐	Logical……..	☐	☐	Hypochondria……	☐	☐
Somatic……	☐	☐	Tactile……	☐	☐				Antisocial urges……	☐	☐
Other…….	☐	☐	Olfactory……	☐	☐				Obsessions……	☐	☐
									Suicidal ideations…..	☐	☐

RN _____

Individual _____ Date _____

Behaviors

Are medications used to control any behaviors? ☐ Y ☐ N Currently on formal Behavior Plan? ☐ Y ☐ N

	Y	N		Y	N		Y	N
Hurtful to self…….	☐	☐	Uncooperative (describe)……	☐	☐	Hurtful to others……	☐	☐
PICA……...	☐	☐	Disruptive (describe)……	☐	☐	Destructive to property……	☐	☐
History of suicide attempt…	☐	☐						

Behaviors: Description, frequency, severity and outcomes. What are effective prevention or redirection strategies?

Communication

Primary language:

Mark ways that pain is communicated.

	Y	N		Y	N		Y	N
Verbal	☐	☐	Facial expressions	☐	☐	Touch	☐	☐
Limited verbal	☐	☐	Eye movement	☐	☐	Body language	☐	☐
Non-verbal	☐	☐	Paralinguistics (sounds)	☐	☐	Acting out	☐	☐
Gestures	☐	☐				Head banging	☐	☐
						Other behaviors (describe)	☐	☐
Able to use pain scale	☐	☐	Faces pain scale	☐	☐	Numeric Scale 1 (least) – 10 (greatest)	☐	☐

Comments

RN _____

Individual ________________________________ Date _________________

V. Implementation Assessment

Health care and Decision Making Capacity

The preceding review of functional capabilities, physical and cognitive status, and limitations indicate this individual's highest level of ability to make health care decisions.

☐ Probably can make higher level decisions (such as whether to undergo or withdraw life sustaining treatments that require understanding the nature, probable consequences, burdens and risks of proposed treatment).

☐ Probably can make limited decisions that require simple understanding, able to direct own health care, including delegated tasks.

☐ Probably can express agreement with decisions proposed by someone else.

☐ Cannot effectively participate in any kind of health care decision making.

Stability and Predictability and Need to Reassess

Health Topic	Is a long-term need non-fluctuating consistent?		Status change possible, or likely to need regular nursing care		Frequency of RN reassessment
	Y	N	Y	N	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Knowledge: Describe key health understandings/demonstrations.

Health Topic	Description	Individual			IDT		
		Y	N	N/A	Y	N	N/A
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐

RN ________________________

Individual _____ Date _____

Health Topic	Description	Individual			IDT		
		Y	N	N/A	Y	N	N/A
	Knowledgeable	☐	☐	☐	☐	☐	☐
	Demonstrates Technique	☐	☐	☐	☐	☐	☐
Comments							

RN _____

Individual _____ Date _____

Individual in Comprehensive Assessment

Individual

☐ I have participated in decisions about the overall management of my health care. [§225.1(2)]

☐ I can make all of my own decisions, and am able to direct own health care.

or

☐ I have a guardian, LAR or IDT member act as my client responsible adult (CRA).

Printed Name	Signature	Date

CRA ☐ **IDT to serve as CRA**

☐ I have participated in decisions about the overall management of health care. [§225.1(2)]

Printed Name	Signature	Date

Registered Nurse (RN)

I have developed this plan and retain accountability for delegated tasks. Each assistive personnel's competency will be verified before allowing delegated tasks to be performed without direct nursing supervision. An RN will be immediately accessible by phone to the assistive personnel when the task is performed.

Printed Name	Signature	Date

RN _____

Individual _____ Date _____

Nurse Supervision

Determine, in consultation with the individual, guardian/LAR and/or IDT, the level of supervision and frequency of supervisory visits, taking into account: the stability of the individual's status; the training, experience and capability of the assistive personnel to whom the nursing task is delegated; the nature of the nursing task being delegated; the proximity and availability of the RN to the unlicensed person when the task will be performed and the level of participation of the individual guardian/LAR and/or IDT. [§225.9(a)(3)(A-E)]

RN follow-up to monitor competency of assistive personnel

- ☐ not applicable, no tasks are delegated
- ☐ once additionally within the first _____, then
  - ☐ monthly
  - ☐ quarterly
  - ☐ once additionally within the year
  - ☐ annually
- ☐ other (med minders, insulin)

Additional monitoring of assistive personnel by an RN or LVN

- ☐ not applicable; no additional monitoring is needed
- ☐ once additionally within the first _____ , then
  - ☐ monthly
  - ☐ quarterly
  - ☐ once additionally within the year

Notes

RN _____

Individual _____ Date _____

Safe Administration of Medications

Based on a comprehensive review of functional capabilities, physical and cognitive status, limitations and natural supports rate this individual's ability to take his/her own medications in a safe and appropriate manner according to the 5 Rights of Medication Administration (correct person, medication [what, why], dose, time, route). **RN Delegation Worksheet** ☐ Attached ☐ Deferred

☐ **Self-Administration of Medication.** Individual knows how to safely take each medication (what, why) dose, route, time of each medication. The individual is competent to safely self-administer medications independently or independently with ancillary aid provided to the individual in the individual's self-administered medication treatment or regimen, such as reminding an individual to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storing area, and assisting in reordering medications from a pharmacy. **No RN Delegation is necessary.** [§225.1(3)]

☐ **Administration of medication** to an individual by a paid unlicensed person(s) to ensure that medications are received safely. Administration of medications includes removal of an individual/unit dose from a previously dispensed, properly labeled container; verifying it with the medication order; giving the correct medication and the correct dose to the proper individual at the proper time by the proper route; and accurately recording the time and dose given. [TX BON §225.4(2)]

☐ **RN delegation necessary to ensure safe medication administration.**

RN can safely authorize unlicensed personnel to administer medications for stable and predictable conditions as defined in §225.4(11) not requiring nursing judgment. Competency of each assistive personnel, including the ability to recognize and inform the RN of individual changes related to the task must be verified by RN. The six rights of delegation (the right task, the right person to whom the delegation is made, the right circumstances, the right direction and communication by the RN, the right supervision, and the right documentation) and all criteria at §225.9 must be met. Individual (if competent), guardian/LAR and/or IDT must approve the decision of the RN to delegate tasks in writing. See Delegation Criteria at §225.9, §225.10.

Routes That May Be Delegated

☐ **The RN has determined that delegation is not required for oral, topical and metered dose inhalers**. The RN has determined that the medications not being delegated to paid unlicensed staff are for a stable or predictable condition. The RN or LVN, under the direction of an RN, has trained and determined the paid unlicensed staff(s) competency. [Human Resources Code, Chapter 161, Subchapter D]

☐ **Must be administered by a licensed nurse.** Medications that **may not be delegated** are:

RN _____

Individual _____ Date _____

VI. Summary

Summary/Clinical Impressions

Strengths as related to health
Consultations recommended
Summary

Nursing Service Plan

Concerns/Nursing Diagnoses
Intervention/Strategies
Desired Outcomes/Goals

Print Name and Credentials	Signature	Date

RN _____